Focus Care Plan Documentation Guidance

Participant Care Plan
Participant care plans are used for nutrition counseling/issues relating to a specific participant and are mandatory for high risk participants. One goal is required to be entered. Since this goal will be displayed on the Family panel for the participant, be sure to make it something that you/other staff will find useful for follow up at the next appointment.

Family Care Plan
Family care plans are used for nutrition counseling/issues relating to several family members such as all children, breastfeeding mom/baby, etc. Family care plans should only be used for members of a family that are not high risk. One goal is required to be entered. This goal will display on the Family panel in the Family Data section.

Parts of a Care Plan
Both participant and family care plans include the information listed below (however the S, O, and A will not auto populate in a family care plan). Entering at least one goal is the only part of the care plan that is required. However, it is important to enter information in the other sections of the care plan if it is needed to make a complete care plan and will be helpful to other staff in carrying out the plan or providing follow up at the participant's next appointment.

- Subjective: Information entered into the Nutrition Interview text boxes will pull into the subjective area of the care plan. Additional subjective information that was not documented during the Nutrition Interview such as comments from the participant (symptoms, feelings, history, etc.) and follow up on previous goals can be documented in the open text box.
- Objective: Information such as age, category, weight, height, growth percentile, and hemoglobin data entered in previous Focus panels will pull into the objective area of the care plan. Additional objective information provided by the participant such as physical/lab findings, medications, etc. can be documented in the open text box.
- Assessment: Nutrition risk codes added in previous Focus panels will pull into the assessment area of the care plan. Additional assessment information including justification for assigning a manually assigned risk code (that can't be documented as part of the Nutrition Interview) can be documented in the open text box.
- Topics: Counseling topics that have been documented in the Nutrition Education panel are pulled into this area.
- Pamphlets: Nutrition education materials that have been documented in the Nutrition Education panel are pulled into this area.
- Goal: Enter what the participant states they will work on or do. One goal is required and should be participant-centered, specific, and time sensitive. An example of a goal focused on eating more vegetables could be "offer fresh vegetables for an afternoon snack three times a week" or "find one new recipe for cooking vegetables and include in a meal this week."
- Referrals: Referrals provided to the participant that have been documented in the Referrals panel are pulled into the referral area of the care plan.
- Counseling/Education: Additional counseling and nutrition education information can be entered into the text box to clarify or enhance the topics and counseling points entered on the Nutrition Education panel.
- Plan: The plan is a place to record information to be covered at the next appointment or additional action to be taken on the issue.

Tips for Developing Goals

- Specific goals give a clear picture of what the outcome should be. Start by listening for and asking what change the participant wants to see and why it is important. That answer will help you identify the core of the goal. A general goal would be, "eat more fruits and vegetables." A more specific goal would be, "eat 3-5 fruit/veggies daily, one with each meal/snack." Specifying the number of servings and times per day makes it clear and simple.
- Measurable goals assess progress or even any improvements. If it answers how much or how many, it tells you when you will know the goal is accomplished. It can be measured by the number of times it is being done daily, weekly, etc.
- Attainable goals should be set high enough to give the participant a feeling of accomplishment when reached but not so high that they will feel defeated if not. They need to feel encouraged, not discouraged, because of goal-setting.
- Realistic goals are those that the participant is not only willing, but able to achieve. This includes designing a plan that may remove any obstacles that would keep them from reaching the goal. For example, purchasing enough fruits/veggies to have one with each meal or discussing inexpensive options, may give the participant a way to see how the goal can be met.
- Timely goals have a timeframe in which to accomplish the goal. Otherwise they have no sense of urgency, which may lead to a lack of commitment to get started.

High Risk Participant Care Plans

The requirements for completing a care plan for high risk participants have not changed. However you will now have to develop a goal with the participant. Since many of the high risk codes are medical conditions, there may not be a specific goal the participant needs to work on in relation to that risk, especially if they have the medical condition under control. In that situation, your goal could be focused on another risk or area they are working on.

Resolving Goals

The goal entered on either a participant or family care plan displays on the Family panel until a new goal is entered on a new care plan. If the goal has been resolved prior to the end of the certification period and no new goal will be set, create a new care plan, re-enter the goal adding something like "goal has been resolved" or "goal accomplished".

Comments/Alerts

Since a goal is now required for all care plans, participant/family issues that don't necessarily relate to nutrition counseling/issues should be documented on the Comments/Alerts panel. If a care plan update is needed or done and the client is still working on their goal, simply re-enter the goal on your new care plan.

Food Package Comments

Since a goal is now required for all care plans, any changes to the food package or other food package issues would best be documented on/in the Comments section of the Food Package panel. If a care plan is done or needed regarding food package issues and the client is still working on their goal, simply re-enter the goal on your new care plan.

Wichealth.org Lesson Completion, Care Plans, and User Action Statements

When a participant completes a lesson through wichealth.org, it will now automatically be entered on the Nutrition Education panel in Focus. The date the lesson was completed and the nutrition education topic will be captured. You will no longer need to enter a nutrition education record after receiving the lesson certificate of completion, and it is no longer necessary to save the certificates of completion that are emailed. However you will still want to capture what the participant states they are going to do after completing the wichealth.org lesson or the user action statement if captured on the certificate. The user action statement can be summarized and entered as a goal on either a participant or family care plan.